

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Apple Rehab West Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 308 Savin Avenue West Haven, CT 06516	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for medication and treatment administration, the facility failed to notify a provider of medication and treatment omissions following an abdominal burn that the resident sustained in the facility. The findings include:</p> <p>Resident #1's diagnoses included dementia with behavioral disturbances.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) score of three (3) indicative of severely impaired cognition and required setup assistance with eating, substantial assistance with bed mobility and was dependent on staff for transfers.</p> <p>The Resident Care Plan (RCP) dated 3/10/25 identified Resident #1 had skin abnormalities due to coffee that was spilled on his/her abdomen on 3/9/25 resulting in a second-degree burn (damage to the outer layer of skin and part of the underlying layer). Interventions included to ensure that a secured lid is in place before serving Resident #1 hot beverages and consult with the wound care nurse specialist as ordered/needed.</p> <p>A facility Reportable Event (RE) form dated 3/10/25 identified that on 3/9/25 at 8:30 AM Resident #1 spilled coffee on his/her abdomen resulting in a second-degree burn. The RE identified new orders were obtained to apply Silvadene (a topical cream used to treat second and third-degree burns) twice daily to the area for ten (10) days and obtain vital signs every shift for three (3) days.</p> <p>A nurse's note dated 3/9/25 at 10:30 PM identified Resident #1 spilled coffee on his/her abdomen during breakfast, redness was observed to the abdomen, the skin was intact, vital signs were within normal limits and Resident #1 was not in distress. The note identified ice was applied to the area for twenty (20) minutes. The note further identified that on the 3:00 PM to 11:00 PM shift, blisters filled with yellow drainage were noted to the abdomen, the Nursing Supervisor and APRN were notified, and a new order was obtained for Silvadene cream twice daily for 10 days and to obtain vital signs for 3 days.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An APRN note dated 3/10/25 at 2:29 PM identified Resident #1 spilled coffee on his/her abdomen over the weekend, sustained a second-degree burn close to the right lateral (away from the midline) umbilicus (belly button) measuring approximately 6 centimeters (cm) by 5 cm, and that Silvadene cream was ordered.</p> <p>a. A physician's order dated 9/1/23 directed to complete a pain assessment every shift.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that a pain assessment was not signed off as completed on the day shift (7:00 AM to 3:00 PM) on 3/12/25.</p> <p>Review of the clinical record failed to identify a pain assessment was completed on the day shift of 3/12/25.</p> <p>b. A physician's order dated 9/2/23 directed to administer Miralax (a treatment for constipation) oral powder 17 grams (gm), give one scoop by mouth in the morning for constipation.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Miralax powder 17 grams (gm) was not signed off as administered on 3/12/25 at 9:00 AM.</p> <p>Review of the clinical record failed to identify Miralax powder 17 gm was administered to Resident #1 on 3/12/25 at 9:00 AM or that a provider was notified of the missed dose.</p> <p>c. A physician's order dated 8/23/24 directed to administer Risperdal 1 milligram (mg) in 1 milliliter (mL), give 0.5 mL by mouth two times a day for agitation.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Risperdal oral solution 1 milligram (mg) in 1 milliliter (mL) give 0.5 mL was not signed off as administered on 3/12/25 at 1:00 PM.</p> <p>Review of the clinical record failed to identify Risperdal oral solution 1 milligram (mg) in 1 milliliter (mL) give 0.5 mL was administered to Resident #1 on 3/12/25 at 1:00 PM or that a provider was notified of the missed dose.</p> <p>d. A physician's order dated 8/29/24 directed to administer Risperdal (an antipsychotic) oral tablet, give 0.75 milligram (mg) by mouth one time a day for anxiety.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Risperdal oral tablet 0.75 milligrams (mg) was not signed off as administered on 3/12/25 at 9:00 AM.</p> <p>Review of the clinical record failed to identify Risperdal oral tablet 0.75 milligrams (mg) was administered to Resident #1 on 3/12/25 at 9:00 AM or that a provider was notified of the missed dose.</p> <p>e. A physician's order dated 3/9/25 directed to obtain vital signs every shift for 3 days, administer Tylenol (pain reducer) 325 milligram (mg) tablets give two (2) tablets by mouth every four (4) hours for pain for seven (7) days.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration Record (MAR) for March 2025 identified that Resident #1's vital signs were not obtained on the day shift (7:00 AM to 3:00 PM) on 3/12/25 and Tylenol 325 milligram (mg) tablets were not administered on 3/12/25 at either 8:00 AM or 12:00 PM as scheduled.</p> <p>Review of nurse's notes failed to identify any documentation on 3/12/25 for Resident #1, including that a provider had been notified of the missed doses of Tylenol 325 mg tablets at 8:00 AM or 12:00 PM.</p> <p>Review of vital signs documentation failed to identify that vital signs were obtained on 3/12/25 per physician's order.</p> <p>f. A physician's order dated 3/10/25 directed to apply Silvadene cream 1 percent (%) to the stomach topically twice daily for a burn.</p> <p>Review of the Treatment Administration Record (TAR) for March 2025 identified that the Silvadene cream 1% was not signed off as administered on 3/12/25 at 9:00 AM</p> <p>Review of nurse's notes dated 3/12/25 failed to identify that the Silvadene cream 1% treatment was administered on 3/12/25 at 9:00 AM or that a provider was notified of the missed treatment.</p> <p>Interview with RN #2 on 4/1/25 at 2:36 PM identified that it is difficult to administer medications to Resident #1 and if she did not sign the medications off, she did not administer them. RN #2 indicated she should have documented the medication omissions in a nurse's note and should have notified the provider of the medication omissions, she did not and was unsure why. RN #2 indicated she never saw Resident #1 in pain but that she should have completed and documented a pain assessment per the order.</p> <p>Interview with APRN #2 on 4/1/25 at 3:21 PM identified that he should be notified of residents who missed or refused medications so monitoring could be initiated accordingly. He identified that the facility should follow the policy and protocol for physician notification and following physician's orders.</p> <p>Interview with the DNS on 4/1/25 at 3:35 PM identified the provider should be notified of all medication omissions, physician orders should be followed, and all administered medication and treatments should be documented. She identified that she was unaware that a nurse did not administer medications and treatments, did not document, and did not notify a provider of medication omissions for Resident #1.</p> <p>Review of the Medication Administration policy directed, in part, that all medications shall be administered safely and accurately in accordance with physician's orders, facility protocols and applicable state and federal regulations. Document the administration in the MAR immediately after giving the medication. Monitor residents for therapeutic side effects and potential side effects of medications. Document all incidents of medication errors or adverse reactions in the resident's record and facility incident log.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for medication and treatment administration, the facility failed to ensure that medications and treatments were administered per physician's orders. The findings include:</p> <p>Resident #1's diagnoses included dementia with behavioral disturbances.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and required setup assistance with eating, substantial assistance with bed mobility and was dependent on staff for transfers.</p> <p>The Resident Care Plan (RCP) dated 3/10/25 identified Resident #1 had skin abnormalities due to coffee that was spilled on his/her abdomen on 3/9/25 resulting in a second-degree burn (damage to the outer layer of skin and part of the underlying layer). Interventions included to ensure that a secured lid is in place before serving Resident #1 hot beverages and consult with the wound care nurse specialist as ordered/needed.</p> <p>A facility Reportable Event (RE) form dated 3/10/25 identified that on 3/9/25 at 8:30 AM Resident #1 spilled coffee on his/her abdomen resulting in a second-degree burn. The RE identified new orders were obtained to apply Silvadene (a topical cream used to treat second and third-degree burns) twice daily to the area for ten (10) days and obtain vital signs every shift for three (3) days.</p> <p>A nurse's note dated 3/9/25 at 10:30 PM identified Resident #1 spilled coffee on his/her abdomen during breakfast, redness was observed to the abdomen, the skin was intact, vital signs were within normal limits and Resident #1 was not in distress. The note identified ice was applied to the area for twenty (20) minutes. The note further identified that on the 3:00 PM to 11:00 PM shift, blisters filled with yellow drainage were noted to the abdomen, the Nursing Supervisor and APRN were notified, and a new order was obtained for Silvadene cream twice daily for 10 days and to obtain vital signs for 3 days.</p> <p>An APRN note dated 3/10/25 at 2:29 PM identified Resident #1 spilled coffee on his/her abdomen over the weekend, sustained a second-degree burn close to the right lateral (away from the midline) umbilicus (belly button) measuring approximately 6 centimeters (cm) by 5 cm, and that Silvadene cream was ordered.</p> <p>a. A physician's order dated 9/1/23 directed to complete a pain assessment every shift.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that a pain assessment was not signed off as completed on the day shift (7:00 AM to 3:00 PM) on 3/12/25.</p> <p>Review of the clinical record failed to identify a pain assessment was completed on the day shift of 3/12/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. A physician's order dated 9/2/23 directed to administer Miralax (a treatment for constipation) oral powder 17 grams (gm), give one scoop by mouth in the morning for constipation.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Miralax powder 17 grams (gm) was not signed off as administered on 3/12/25 at 9:00 AM.</p> <p>Review of the clinical record failed to identify Miralax powder 17 gm was administered to Resident #1 on 3/12/25 at 9:00 AM or that a provider was notified of the missed dose.</p> <p>c. A physician's order dated 8/23/24 directed to administer Risperdal 1 milligram (mg) in 1 milliliter (mL), give 0.5 mL by mouth two times a day for agitation.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Risperdal oral solution 1 milligram (mg) in 1 milliliter (mL) give 0.5 mL was not signed off as administered on 3/12/25 at 1:00 PM.</p> <p>Review of the clinical record failed to identify Risperdal oral solution 1 milligram (mg) in 1 milliliter (mL) give 0.5 mL was administered to Resident #1 on 3/12/25 at 1:00 PM or that a provider was notified of the missed dose.</p> <p>d. A physician's order dated 8/29/24 directed to administer Risperdal (an antipsychotic) oral tablet, give 0.75 milligram (mg) by mouth one time a day for anxiety.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Risperdal oral tablet 0.75 milligrams (mg) was not signed off as administered on 3/12/25 at 9:00 AM.</p> <p>Review of the clinical record failed to identify Risperdal oral tablet 0.75 milligrams (mg) was administered to Resident #1 on 3/12/25 at 9:00 AM or that a provider was notified of the missed dose.</p> <p>e. A physician's order dated 3/9/25 directed to obtain vital signs every shift for 3 days, administer Tylenol (pain reducer) 325 milligram (mg) tablets give two (2) tablets by mouth every four (4) hours for pain for seven (7) days.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Resident #1's vital signs were not obtained on the day shift (7:00 AM to 3:00 PM) on 3/12/25 and Tylenol 325 milligram (mg) tablets were not administered on 3/12/25 at either 8:00 AM or 12:00 PM as scheduled.</p> <p>Review of nurse's notes failed to identify any documentation on 3/12/25 for Resident #1, including that a provider had been notified of the missed doses of Tylenol 325 mg tablets at 8:00 AM or 12:00 PM.</p> <p>Review of vital signs documentation failed to identify that vital signs were obtained on 3/12/25 per physician's order.</p> <p>f. A physician's order dated 3/10/25 directed to apply Silvadene cream 1 percent (%) to the stomach topically twice daily for a burn.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Treatment Administration Record (TAR) for March 2025 identified that the Silvadene cream 1% was not signed off as administered on 3/12/25 at 9:00 AM</p> <p>Review of nurse's notes dated 3/12/25 failed to identify that the Silvadene cream 1% treatment was administered on 3/12/25 at 9:00 AM or that a provider was notified of the missed treatment.</p> <p>Interview with RN #2 on 4/1/25 at 2:36 PM identified that it is difficult to administer medications to Resident #1 and if she did not sign the medications off, she did not administer them. RN #2 indicated she should have documented the medication omissions in a nurse's note and should have notified the provider of the medication omissions, she did not and was unsure why. RN #2 indicated she never saw Resident #1 in pain but that she should have completed and documented a pain assessment per the order.</p> <p>Interview with APRN #2 on 4/1/25 at 3:21 PM identified that he should be notified of residents who missed or refused medications so monitoring could be initiated accordingly. He identified that the facility should follow the policy and protocol for physician notification and following physician's orders.</p> <p>Interview with the DNS on 4/1/25 at 3:35 PM identified the provider should be notified of all medication omissions, physician orders should be followed, and all administered medication and treatments should be documented. She identified that she was unaware that a nurse did not administer medications and treatments, did not document, and did not notify a provider of medication omissions for Resident #1.</p> <p>Review of the Medication Administration policy (undated) directed, in part, that all medications shall be administered safely and accurately in accordance with physician's orders, facility protocols and applicable state and federal regulations. Document the administration in the MAR immediately after giving the medication. Monitor residents for therapeutic side effects and potential side effects of medications. Document all incidents of medication errors or adverse reactions in the resident's record and facility incident log.</p> <p>Although requested, a policy on following physician's orders was not obtained.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for medication and treatment administration, the facility failed to ensure complete and accurate documentation of a resident record when medications and treatments were not signed off when administered/completed. The findings include:</p> <p>Resident #1's diagnoses included dementia with behavioral disturbances.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and required setup assistance with eating, substantial assistance with bed mobility and was dependent on staff for transfers.</p> <p>The Resident Care Plan (RCP) dated 2/14/25 identified that Resident #1 has impaired memory, recall and decision-making skills related to dementia. Interventions included to offer medications as ordered, be aware of the effectiveness and side effects, and make adjustments as ordered.</p> <p>a. A physician's order dated 9/1/23 directed to complete a pain assessment on Resident #1 every shift.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that a pain assessment was not signed off as completed on the day shift (7:00 AM to 3:00 PM) on 3/6/25.</p> <p>Review of the clinical record failed to identify a pain assessment was completed for Resident #1 on the day shift of 3/6/25.</p> <p>b. A physician's order dated 9/2/23 directed to administer Miralax (a treatment for constipation) oral powder 17 grams (gm), give one scoop by mouth in the morning for constipation.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Miralax powder 17 grams (gm) not signed off as administered on 3/6/25 at 9:00 AM.</p> <p>Review of the clinical record failed to identify Miralax powder 17 gm was administered to Resident #1 on 3/6/25 at 9:00 AM.</p> <p>c. A physician's order dated 8/23/24 directed to administer Risperdal 1 milligram (mg) in 1 milliliter (mL), give 0.5 mL by mouth two times a day for agitation.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Risperdal oral solution 1 milligram (mg) in 1 milliliter (mL) give 0.5 mL was not signed off as administered on 3/6/25 at 1:00 PM.</p> <p>Review of the clinical record failed to identify Risperdal oral solution 1 milligram (mg) in 1 milliliter (mL) give 0.5 mL was administered to Resident #1 on 3/6/25 at 1:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d. A physician's order dated 8/29/24 directed to administer Risperdal (an antipsychotic) oral tablet, give 0.75 milligram (mg) by mouth one time a day for anxiety.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 identified that Risperdal oral tablet 0.75 milligrams (mg) was not signed off as administered on 3/6/25 at 9:00 AM.</p> <p>Review of the clinical record failed to identify Risperdal oral tablet 0.75 milligrams (mg) was administered to Resident #1 on 3/6/25 at 9:00 AM.</p> <p>Interview with LPN #4 on 4/1/25 at 2:39 PM identified that although she should have documented on the medications and treatments for Resident #1 on 3/6/25, she did administer and complete them all, but left early that shift and must have forgotten to document.</p> <p>e. A physician's order dated 3/10/25 directed to apply Silvadene cream 1 percent (%) to the stomach topically twice daily for a burn.</p> <p>Review of the Treatment Administration Record (TAR) for March 2025 identified that the Silvadene cream 1% was not signed off as administered on 3/13/25 at 5:00 PM, 3/14/25 at 5:00 PM or 3/15/25 at 5:00 PM.</p> <p>Review of nurse's notes dated 3/13/25 through 3/15/25 failed to identify that the Silvadene cream 1% treatment was administered on 3/13/25 at 5:00 PM, 3/14/25 at 5:00 PM or 3/15/25 at 5:00 PM.</p> <p>Interview with the DNS on 4/1/25 at 3:35 PM identified the provider should be notified of all medication omissions, physician orders should be followed, and all administered medication and treatments should be documented. She identified that medication and treatment omissions should be reported to a provider for further instruction.</p> <p>Review of the Nursing Documentation policy (undated) directed, in part, that documentation should be completed as soon as possible after care is provided, assessments are conducted, or any significant event occurs, ideally within the same shift. In extenuating circumstances, documentation may be entered at a later time, but it must be clearly indicated as such to maintain transparency and accuracy. All entries must be factual, complete, and reflect the resident's current condition and care provided. Document any changes in the resident's condition, new symptoms, or reactions to treatments immediately and include any actions taken (e.g., physician notification) and resident/family communication.</p> <p>Review of the Medication Administration policy (undated) directed, in part, that all medications shall be administered safely and accurately in accordance with physician's orders, facility protocols and applicable state and federal regulations. Document the administration in the MAR immediately after giving the medication. Monitor residents for therapeutic side effects and potential side effects of medications. Document all incidents of medication errors or adverse reactions in the resident's record and facility incident log.</p>		